

504 Accommodation Plan

sample

NAME _____ DOB _____ DATE _____

SCHOOL _____ GRADE _____

☐ Meets eligibility for 504 services (check all applicable areas)

- | | | |
|--|--|-----------------------------------|
| <input type="checkbox"/> caring for one's self | <input type="checkbox"/> performing manual tasks | <input type="checkbox"/> speaking |
| <input type="checkbox"/> walking | <input type="checkbox"/> seeing | <input type="checkbox"/> hearing |
| <input type="checkbox"/> breathing | <input type="checkbox"/> learning | <input type="checkbox"/> working |
| <input type="checkbox"/> other _____ | | |

Eligibility determined by: _____

Areas of concern: _____

Services required (check all that are applicable)

- | | | |
|--|---|---|
| <input type="checkbox"/> general education | <input type="checkbox"/> interpreter | <input type="checkbox"/> transportation |
| <input type="checkbox"/> school nurse | <input type="checkbox"/> aide | <input type="checkbox"/> vision services |
| <input type="checkbox"/> adaptive P.E. | <input type="checkbox"/> occupational therapy | <input type="checkbox"/> physical therapy |
| <input type="checkbox"/> counseling | <input type="checkbox"/> speech/language services | <input type="checkbox"/> other _____ |

Duration of Accommodation(s)

From _____ To _____ Annual review date _____

Annual review (check one)

continue

terminate

re-evaluate

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